



PEPFAR

# External Engagement Meeting March 16, 2016

*PEPFAR/Tanzania*





**PEPFAR**

**COP 2016 Overview**

# **TOOLS AND PROCESSES**





PEPFAR

# Country Operation Plan (COP) 2016 Summary

## **What is a PEPFAR COP?**

- The Country Operation Plan is a document to inform stakeholders about funding from the U.S. Government for the PEPFAR program supporting the national response to HIV and AIDS.

## **Who is the audience for the PEPFAR Tanzania COP 2016?**

- All stakeholders in the national response to HIV and AIDS, including the U.S. Congress and American people as well as the Government of Tanzania and the Tanzanian people

## **Which information is included in the COP?**

- A narrative overview of the national response to HIV and AIDS and the role of the PEPFAR program within that response
- Annual PEPFAR Work Plans and Budgets for Fiscal Year 2016/17
- Anticipated PEPFAR Results (Targets) for FY 2016/17
- Supplementary data tables and documents to support the analysis and strategic planning for the budgeted funds



# COP 2016 Tools

## Which documents and tools are included in the COP?

1. Strategic Direction Summary (SDS)
  - Narrative to support the strategy, priorities, work plan, and budget
2. Data Pack
  - Used for analyzing epidemiological data
3. Sustainability Index and Dashboard (SID)
  - Measures sustainability across 15 elements of the national response to HIV and AIDS
4. Systems and Budget Optimization Review and Template (SBOR)
  - Prioritizes budgets for program supporting activities
5. PEPFAR Budget Allocation Calculator (PBAC)
  - Uses expenditure data to generate budget code allocations
6. EA Data Navigation Tool and EA-Epi Comparison Tool
  - Uses Expenditure Analysis (EA) data to budget for planned results
7. SIMS Action Planner
  - Site Improvement and Monitoring System for PEPFAR



PEPFAR

# COP 2016 Timeline

## What is the timeline for writing the COP?

- COP 2016 guidance was completed in December 1, 2015
- COP 2016 technical considerations were completed on February 2, 2016
  - Both documents are available online at:  
[www.pepfar.gov/reports/guidance/index.htm](http://www.pepfar.gov/reports/guidance/index.htm)
- PEPFAR Tanzania and the PS Ministry of Health met with PEPFAR senior leadership in Washington, D.C., March 1-4 to share draft budgets, targets, and strategies and receive guidance on the way forward
- March 16 Meeting with External Stakeholders is designed to share draft plans and strategies, receive feedback and input, and inform the final COP submission
- April 14: the COP is submitted to the Office of the Global AIDS Coordinator (OGAC)
- May 18-20: the submitted COP is reviewed in Johannesburg with PEPFAR senior leadership and submitted for final approval by OGAC



PEPFAR

# COP 2016 Processes

## How is the COP completed?

- Shared tools with Government colleagues in January 2016
- Shared guidance documents with civil society and other stakeholders in January 2016
- PEPFAR technical staff work with government counterparts to complete the standard tools, prioritize interventions, geographies, and populations
- PEPFAR HQ and Country Team draft a work plan and balanced budget to share with external stakeholders
- External stakeholders review and submit feedback and recommendations on the draft plan
- PEPFAR Country Team deliberates on feedback to produce the COP
- Submitted COP is reviewed by PEPFAR HQ and external stakeholders in Johannesburg for final approval



PEPFAR

## COP Terminology for Priority Areas

- **“Scale-up to Saturation”** = High burden areas that can achieve 80% of all PLHIV on ART by 2017 with increased effort
- **“Scale-up Aggressive”** = High burden areas that can achieve 80% of all PLHIV on ART by 2018/19 with increased effort
- **“Sustained”** = Lower burden areas that will reach 80% of all PLHIV on ART by 2020 without increased effort



**PEPFAR**

**COP 2016 Overview**

# **STRATEGIES AND PRIORITIES**





PEPFAR

## Continuing Strategies and Priorities for COP 2016

---

1. Reach 80% treatment coverage in the highest burden districts first
2. Rapidly improve pediatric case finding and retention
3. Focus HIV testing on the highest prevalence and at-risk populations:
  - Sex workers
  - Men who have sex with men
  - Injecting drug users
  - Adolescent girls and young women
  - Orphaned and malnourished children
4. Develop innovative prevention interventions for adolescent girls and young women
5. Scale up viral load access
6. Continue expanding VMMC to 80% coverage levels
7. Share quarterly data with CSOs at meetings in Dar es Salaam



## New Strategies and Priorities for COP 2016

1. Adopt Test and START guidelines to treat all PLHIV
  - Phased implementation
2. Implement 6-monthly clinical visits for stable patients
3. Support 3-monthly ARV refills in community settings
4. Expand HIV testing focus to include:
  - Suspected TB cases
  - Sexually transmitted infection (STI) patients
  - Expanded partner notification program of new HIV+ patients
  - Incentivized Peer Network Case Finding Work with the Global Fund on implementing recommendations from the OIG audit to improve the supply chain for medicines
5. Develop Unique Identifier for Health
  - Track HIV patients from testing through to treatment and retention
6. Conduct Quarterly CSO meetings in regional settings

# Sustainability Analysis for Epidemic Control: Tanzania

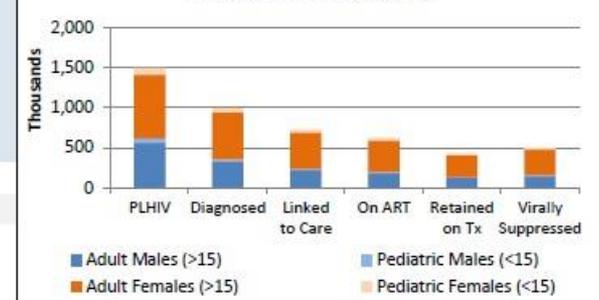
Epidemic Type: Generalized  
 Income Level: Low-income  
 PEPFAR Categorization: Long-term Strategy  
 PEPFAR COP 16 Planning Level: \$430,000,000

SUSTAINABILITY DOMAINS AND ELEMENTS

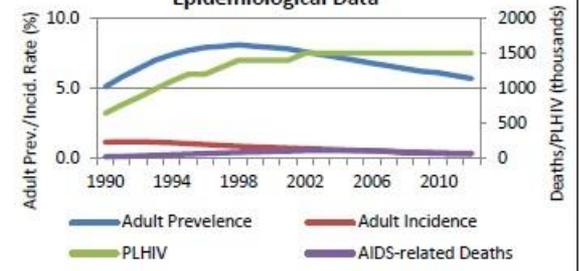
	2016	2017	2018	2019
<b>Governance, Leadership, and Accountability</b>				
1. Planning and Coordination	4.43			
2. Policies and Governance	3.85			
3. Civil Society Engagement	4.17			
4. Private Sector Engagement	4.86			
5. Public Access to Information	5.00			
<b>National Health System and Service Delivery</b>				
6. Service Delivery	3.38			
7. Human Resources for Health	5.00			
8. Commodity Security and Supply Chain	4.94			
9. Quality Management	5.19			
10. Laboratory	3.33			
<b>Strategic Investments, Efficiency, and Sustainable Financing</b>				
11. Domestic Resource Mobilization	1.94			
12. Technical and Allocative Efficiencies	3.17			
<b>Strategic Information</b>				
13. Epidemiological and Health Data	4.70			
14. Financial/Expenditure Data	4.58			
15. Performance Data	5.99			

## CONTEXTUAL DATA

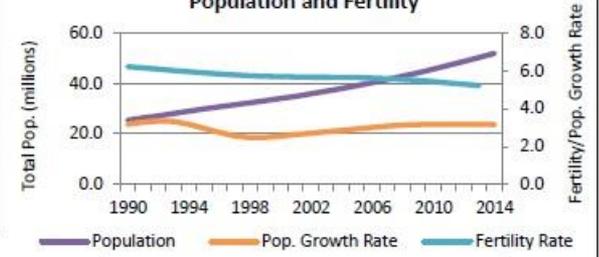
National Clinical Cascade



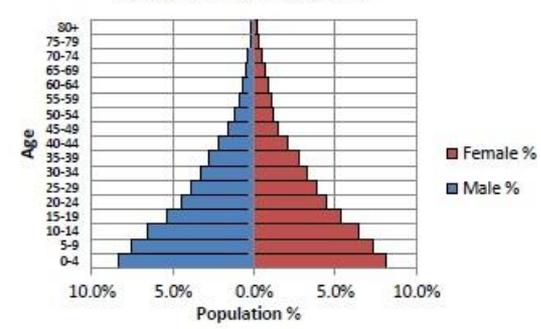
Epidemiological Data



Population and Fertility

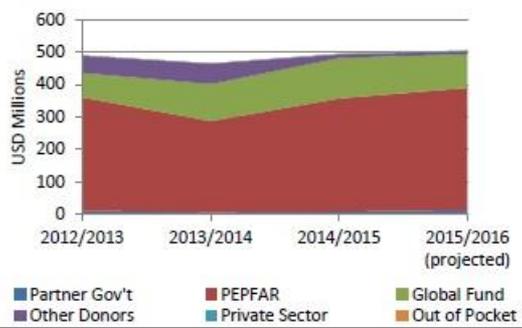


Population Pyramid (2015)

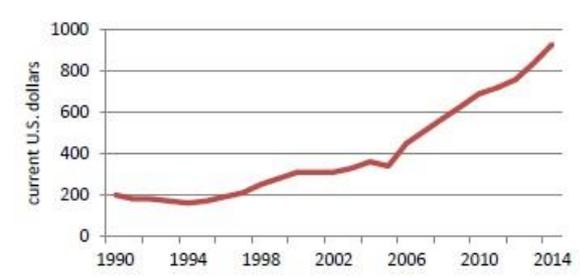


CONTEXTUAL DATA

Financing the HIV Response



GNI Per Capita (Atlas Method)





PEPFAR

# Sustainability Strengths

---

- Public access to information has been steadily improving in:
  - Open data commitments by government leadership
  - Improved information systems for health management and supply chain, with online web portals
  - Big Results Now initiative to track sectoral performance indicators
- Performance data are more readily available in:
  - Nationwide Health Management Information System using the DHIS2
  - Electronic Care and Treatment Center database
  - Electronic Logistics Management and Information System
  - Human Resources for Health Information System



# Sustainability Vulnerabilities

---

## **Proposed priority attention for COP 2016:**

1. Service delivery environment to implement Test and START
2. Human Resources, Data Systems, and Lab Services
3. Adult and pediatric ART retention
4. Patient tracking system for improved HIV testing services and continuum of care, treatment and viral suppression
5. Financing HIV commodities (*e.g.*, ARVs, lab reagents), improved Domestic Resource Mobilizations, and improve the commodity management system



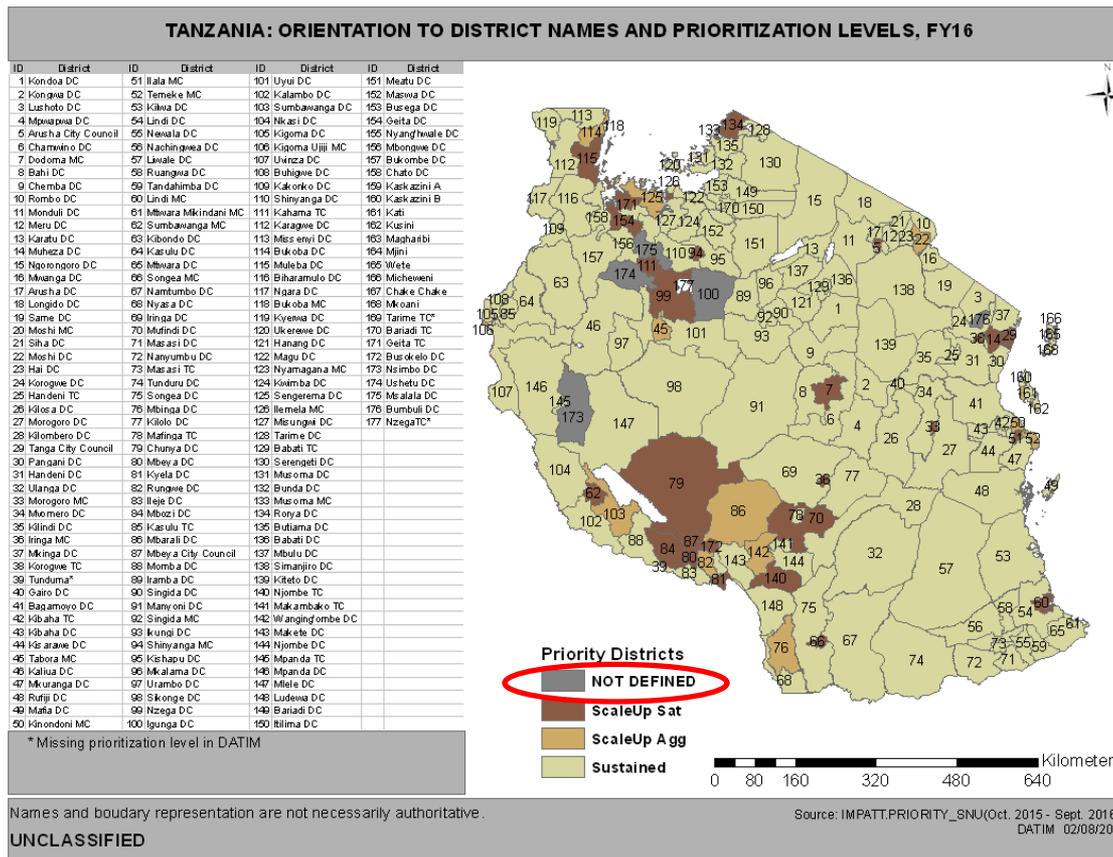
# Programmatic Gaps and Response

Programmatic Gap	Sample Systems Barrier	Outcomes
Alternative Service Delivery Models	Lack of functionality within patient tracking systems to support differentiated service delivery models	<ul style="list-style-type: none"> <li>• Increased HIS capacity to adapt to service delivery model needs</li> </ul>
Adult and Pediatric Retention	Inadequate government systems and tools for facility-community service linkages	<ul style="list-style-type: none"> <li>• Quality Improvement teams involved in facility community linkage</li> </ul>
HIV Testing Services	Inadequate policy guideline to support HIV Testing (age of consent for Testing)	<ul style="list-style-type: none"> <li>• Lower age of consent and disclosure policy adopted and implemented</li> </ul>
ARV and Commodities	Inefficient system for distribution of commodities under new service delivery platform	<ul style="list-style-type: none"> <li>• Supply chain system redesigned using financial and service data to improve distribution under new service delivery models</li> </ul>



PEPFAR

# COP15 and New Council Prioritization Categories



Names and boundary representation are not necessarily authoritative.  
UNCLASSIFIED

Source: IMPATT.PRIORITY\_SNU/Oct. 2015 - Sept. 2016, DATIM 02/08/2016

Council	COP 2015 Prioritization Level	2014 PLHIV	2014 Prevalence (%) all ages	2015 PLHIV	2015 Prevalence (%) ages 15-49
Ushetu DC	Undefined: now scale up aggressive			10,398	6.6
Msalala DC	Undefined: now scale up aggressive			10,051	6.9
Nsimbo DC	Undefined: now sustained			4,580	6.1
Bumbuli DC	Undefined: now sustained			1,412	1.5

“Not Defined” are new councils; included in COP 2016 prioritization process



PEPFAR

## Proposed Updates/Changes in Council Prioritization

- 6 scale-up councils reached >80% coverage
- 2 councils (Shinyanga DC and Ilemela MC) can now reach 80% coverage earlier than 2020
- 1 council (Rungwe DC) can now reach 80% coverage by 2017 (instead of 2018/19)
- Kahama DC has split into two councils (Msalala and Ushetu DC) which will reach 80% coverage by 2018/19
- 2 new councils (Nsimbo DC and Bumbuli) will reach 80% coverage by 2020
- 2 councils in Zanzibar (Mjini and Magharibi) will remain a priority for working with key populations



**PEPFAR**

# **COP 2016 Plan for HIV Epidemic Control**

## **90-90-90 BY 2020**





1<sup>st</sup> 90

90% of all PLHIV know their status



# 1<sup>st</sup> 90: Key Achievements and Opportunities

PEPFAR

## **Achievements to Date:**

- Task sharing approved for Community Health Workers and lay counselors to provide counseling and testing services and to dispense ARVs
- Reduced PEPFAR support for low-yield sites by 2,786 (49%) in Q1 2016
- Improved testing yield from 4.4% in FY2014 to 5.4% in Q1 2016
- Strengthened case finding for infected children through OVC platforms
- Developed standardized M&E tools for Key Population services

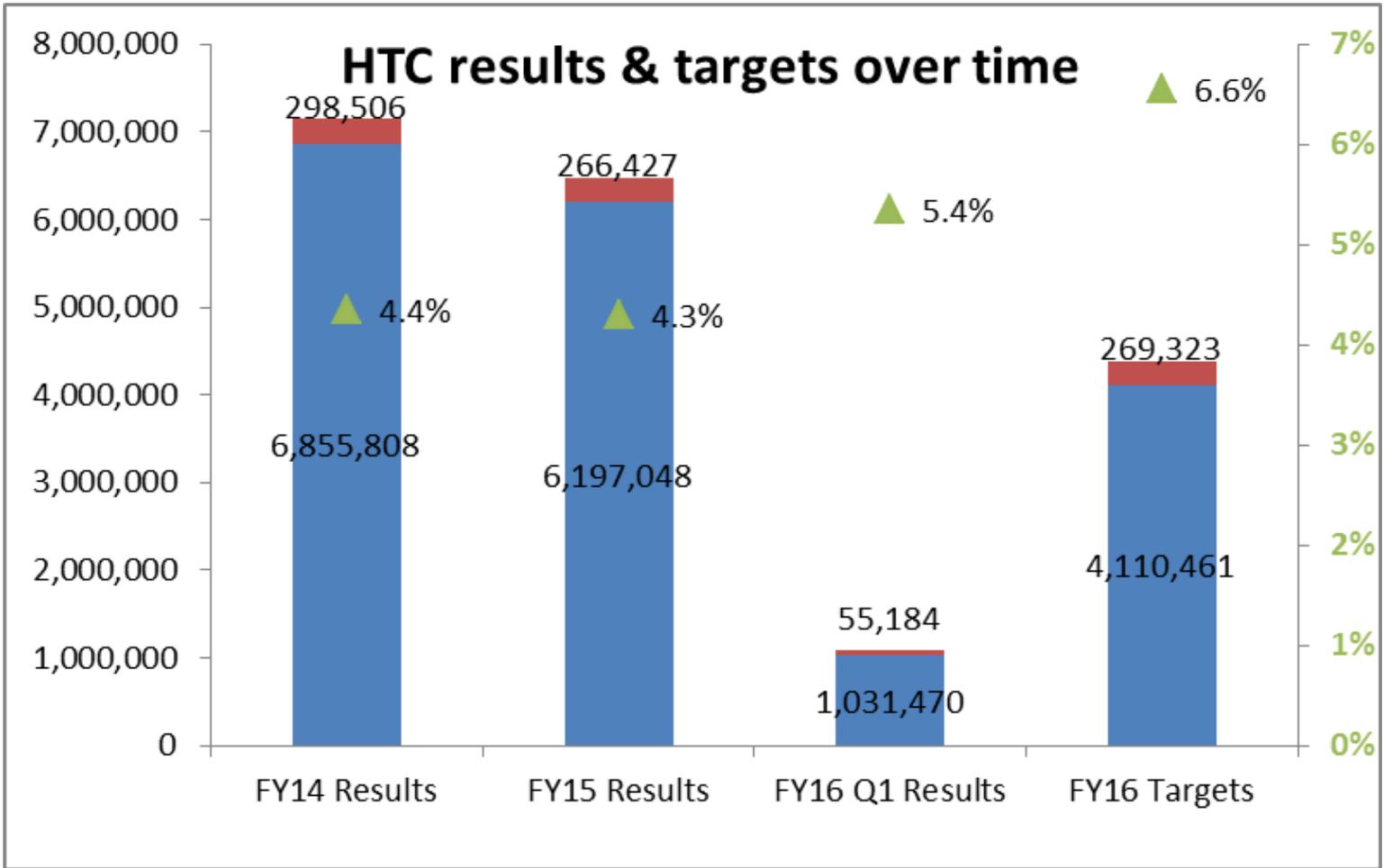
## **Challenges and Opportunities for COP 2016:**

- Inadequate case detection rate to reach treatment targets and epidemic control, including among KPs
- Finding the men as soon as we can guarantee they will get ART



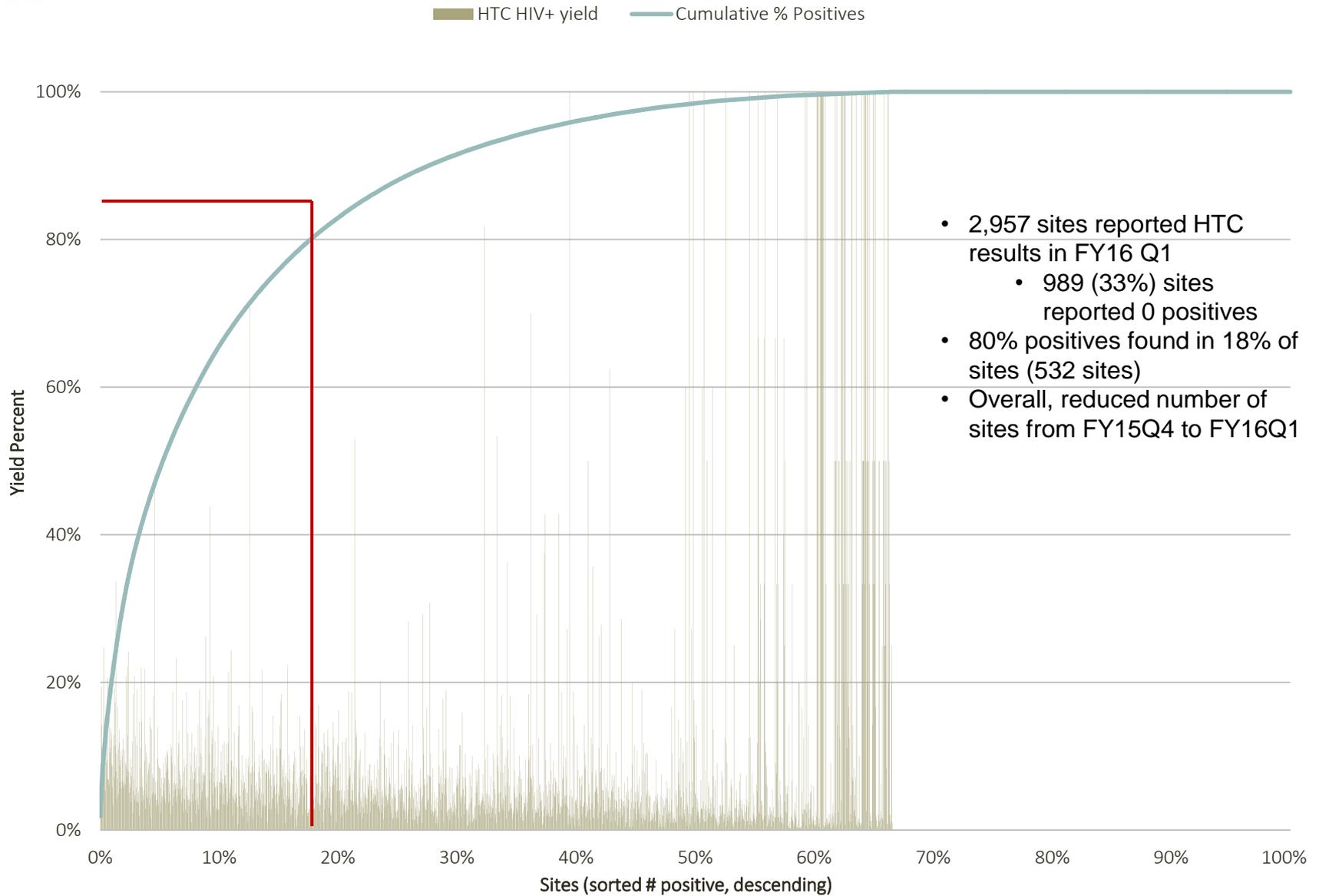
PEPFAR

# FY 2016 HTC aims for more efficient testing: *Improved yield, but lower than yield target* Testing has been more targeted but still needs to improve!





# FY16 Q1 HTC Yield by Site and Cumulative Number of Positives Identified





PEPFAR

# Partner Notification Study

---

- 360 Index clients identified, 438 sexual partners
  - ❖ 318 (73.2%) were spouses
  - ❖ 248 (56.6%) sexual partners were successfully referred to HTS
  - ❖ 234 (95.5%) of the successfully referred partners were reached through passive referrals
  - ❖ 238 (90.0%) received HTS
  - ❖ 61.8% (53.5% male, 67.9% female) tested positive for HIV

## Conclusion

- Partner notification and testing is effective for reaching PLHIV



## COP 16: Innovations to Reach First 90

PEPFAR

### Plans for increasing yield and numbers diagnosed now and in COP 16:

- Scale up partner notification and testing (new)
  - TZ CROI presentation showed high uptake and very high yield
- Incentivize social network testing (new)
- Test TB suspects (new), STI patients (new), and OVC
- Targeted community-level demand creation for testing
- Address issues/policies around stigma

### *Impact of Unique Identifier on First 90:*

*Enable de-duplication of positive tests & tracking of linkages*



2<sup>nd</sup> 90

90% of all identified PLHIV are on  
ART



PEPFAR

## 2nd 90: Achievements and Opportunities

---

### **Achievements**

- Achieved 54% of two-year target for children on ART
- PMTCT Option B+ with over 97% coverage
- Adoption of Test and Start for all populations in DREAMS districts
- Better patient linkages to care, retention and active tracking of Lost to Follow-up (LTFU) clients

### **Challenges/Opportunities**

- Need to ensure supply chain implications are addressed during all stages of planning for new service delivery models



PEPFAR

# Unmet ART need by Council Prioritization (APR)

## TANZANIA: PRIORITY DISTRICTS FY16 AND PEPFAR ART COVERAGE FY15

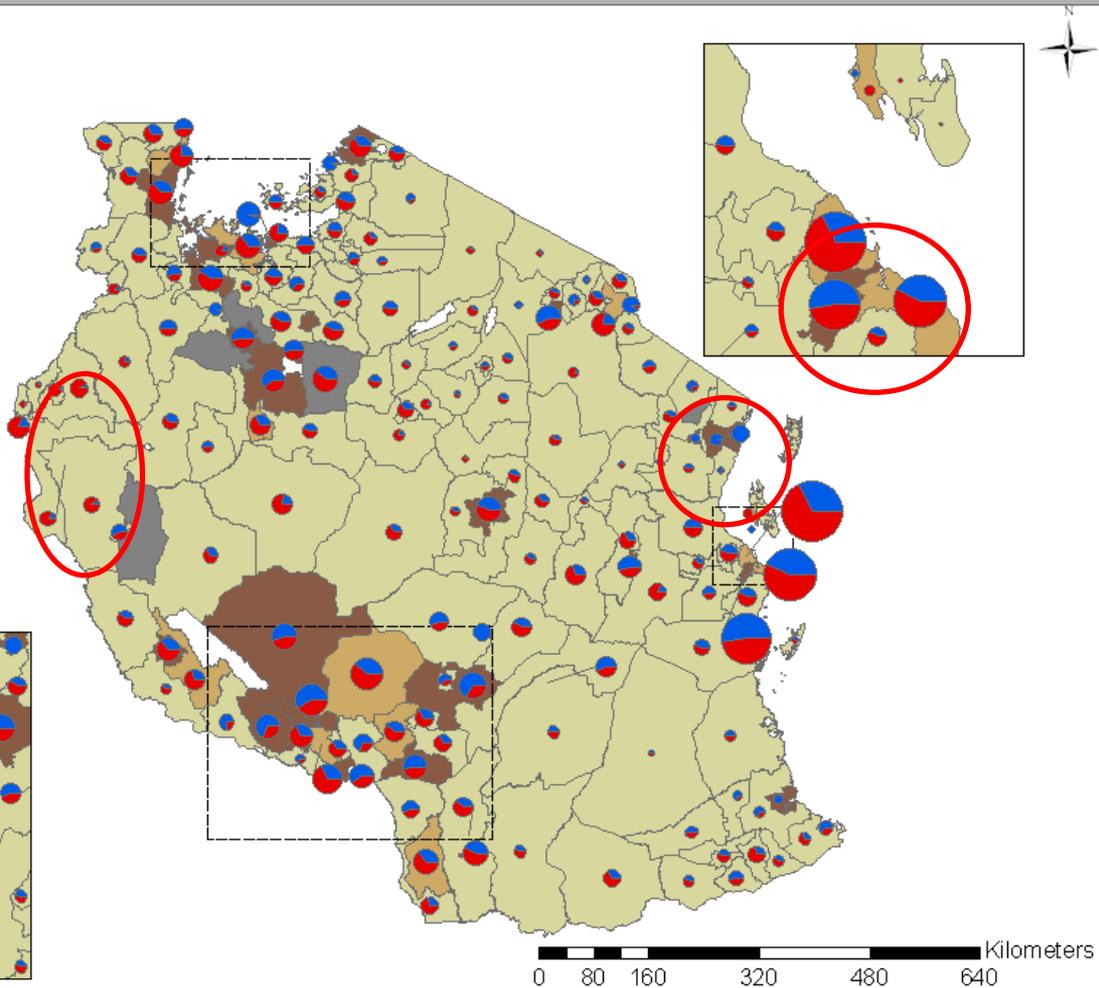
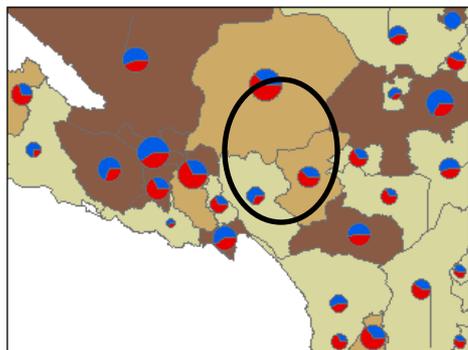
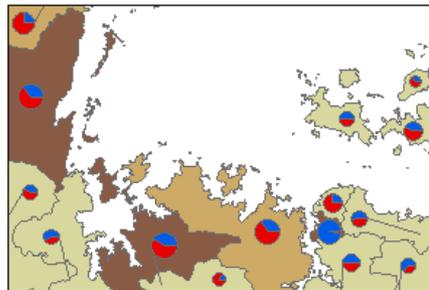
FY15 Number of PLHIV Priority Districts



98296

TX\_CURR APR15  
Other PLHIV

NOT DEFINED  
ScaleUp Sat  
ScaleUp Agg  
Sustained



Names and boundary representation are not necessarily authoritative.

UNCLASSIFIED

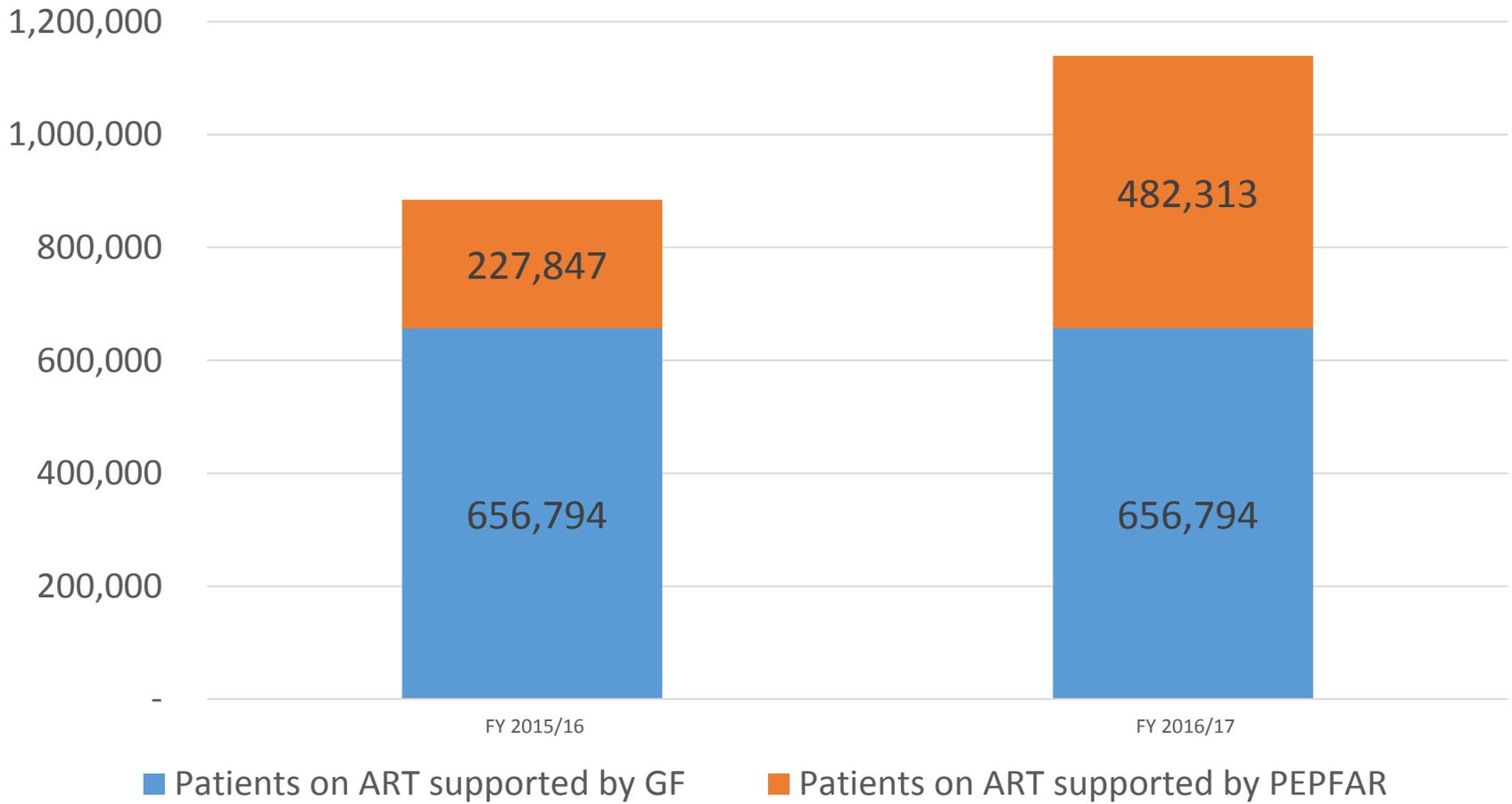
Sources:

- 1. IMPATT.PRIORITY\_SNU (Oct. 2015 - Sept. 2016), DATIM 02/08/2016
- 2. TX\_CURR (Oct. 2014 - Sept. 2015), DATAPACK 02/08/2016
- 3. PLHIV (Oct. 2015 - Sept. 2016), DATAPACK 02/08/2016



# National ARV forecast and PEPFAR programming

PEPFAR is planning to support all ARVs for HIV patients above the GF maximum support level in COP 2016





# Linkage to Care & ART retention

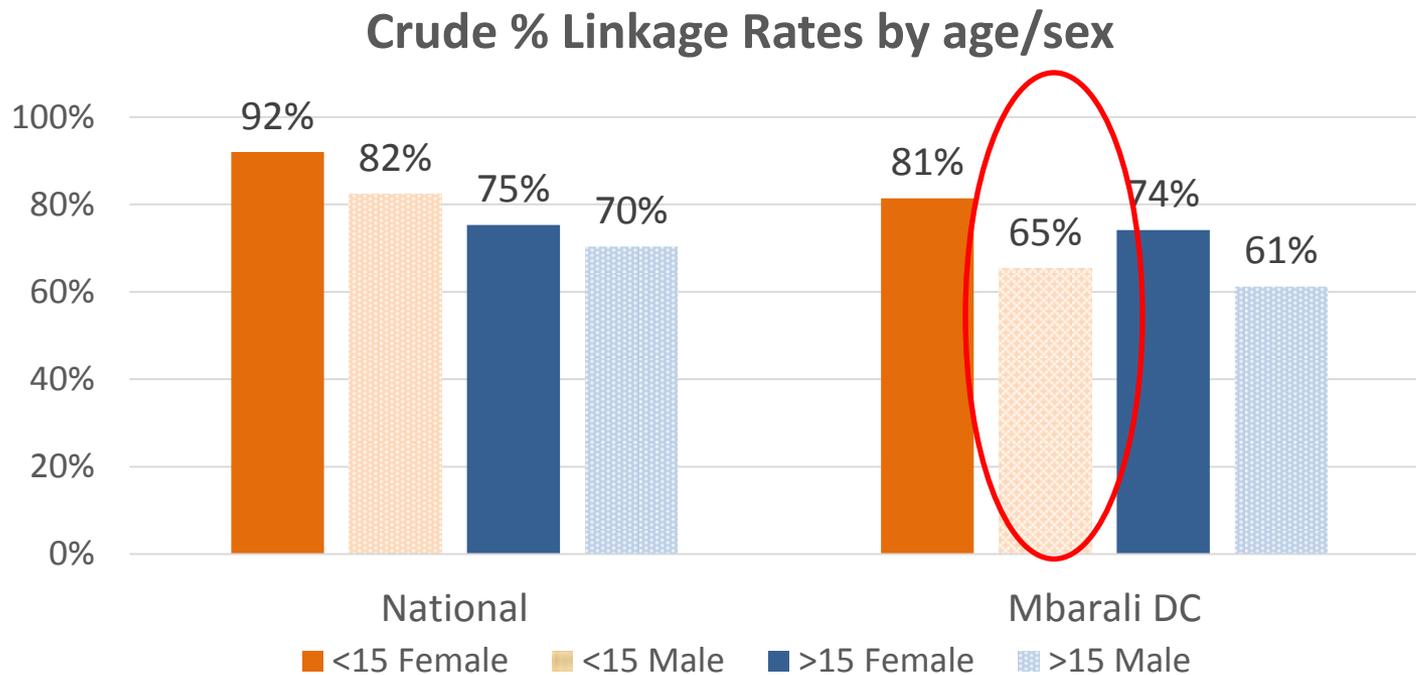
---

- Linkage from Newly Tested Positive to Newly Enrolled in Care was 79% in 2015
- Retention on ART at 12 months was 72%
- Sustained Councils
  - 51% (64/125) had linkage <75%
  - 78% (103/132) had 12-month retention <75%



PEPFAR

## Recommendation: Use council-level data to identify poor linkage and most impacted subgroups at highest risk



- In Mbarali DC, similar regional and national crude % linkage rate for women; BUT for men the rate is 5% and 9% lower respectively
- Possible challenges include mobile communities and challenges in community/facility linkages



# Service packages for stable patients and patients with advanced disease

---

## Stable patients

- Clinic visits 6 months
- ART refill 3 months
- Baseline CD4 and VL monitoring after 6 month then yearly

## Advanced disease

- Monthly clinic visit and refill for ART
- Rapid initiation of ART
- TB screening followed by IPT and
- Intensive follow up



# Differences in service packages across different councils (*e.g.*, scale up to saturation, aggressive scale-up, sustained)

---

## Scale up councils only:

- Demand creation and frequency of supportive supervision
- Use of community support groups for patient tracking
- Training of HCW in scale up councils.
- Cervical cancer screening
- Prevention and response to GBV



## COP 16: Priority Strategies to Reach 2<sup>nd</sup> 90

PEPFAR

---

- Adopt Test and START for all – **Pima Utibiwe**
  - Treat all pre-ART clients
  - Back to treatment campaigns for people who already know they are positive in the community
- New service delivery models to decongest clinics for stable patients
  - Biannual clinic visits for stable patients
  - 3 month refills (build on oral contraceptive model)
  - Decentralize ARV pick up at designated pharmacies within the community/village dispensaries
  - Explore distribution points outside the clinic using community health care workers; peer group pick-ups
- Integrate analysis in monthly partner meetings/quarterly data reviews

*Impact of Unique Identifier on Second 90: Enhance linkage and retention*



3<sup>rd</sup> 90

90% of all PLHIV on ART achieve  
viral suppression



# 3rd 90: Achievements and Opportunities

---

## Achievements

- Successful “back to care” pilot campaigns
- Fully mapped and piloted viral load specimen transport system
- Web-based dashboard for real-time viral load and EID monitoring

## Challenges/Opportunities

- Retention and adherence as we scale to pediatrics, pregnant and breastfeeding women, men, and now test and start
- Adoption of Test and START helps to change the framing to focus on the critical benefits of treatment on the individual’s health



PEPFAR

## What plans are in place for HIV drug resistance surveillance?

- **Plans for implementation of HIV drug resistance surveillance**
  - Revival of HIV Drug resistance Technical working group
  - Implementation of Early warning indicators in Rukwa, Mbeya and Katavi regions
- **What labs will PEPFAR support through FY16 COP? 11 (VL Labs), 955 clinical/ testing laboratory**
- **What initial labs will be supported (i.e. for new patients)? 6 (VL Labs)**
- **What labs will be routinely supported for follow-up, and with what frequency? 11 Labs on quarterly basis**
- **What labs will be supported for patients with advanced disease or failing ART? 11 (VL Labs)**



## Plans to scale-up viral load and harmonize testing platform with EID, TB, and Hepatitis C

- 73 Gene Xpert machines used for TB, also for use in EID, VL & Hepatitis C
- 2 Point of Care Machines being evaluated:
  - Alere Q for EID only and Cepheid Gene Xpert for both for EID and Viral Load.
- Current national clinical guidelines have all HIV positive individuals tested for TB and all TB positive individuals tested for HIV.
- Hub and Spoke System:
  1. Mapping of all facilities to hubs
  2. Identification of courier systems (motorbike, public and commercial courier companies)
  3. Development of a web-based sample tracking and results return system.
- Health Care Workers in all facilities in scale-up councils to be trained on Viral Load Demand Creation



PEPFAR

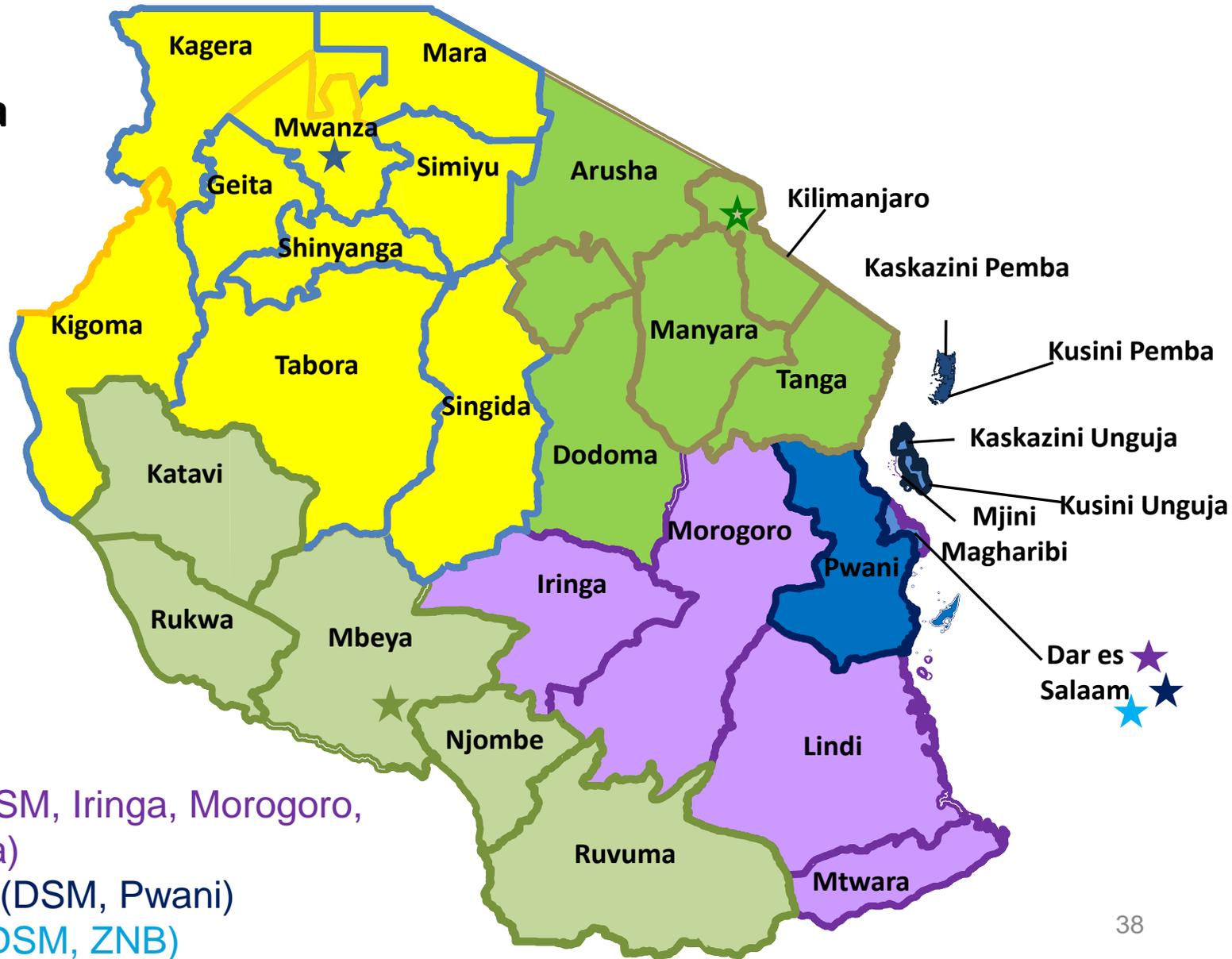
## Recommended strategy for HVL testing in the policy and guidelines

- As routine HVL monitoring is introduced, CD4 monitoring for patients on ART will no longer be performed to monitor patients on ART.
- Routine CD4 testing every six (6) months will be continued for pre-ART patients who require it for determination of ART eligibility.
- Baseline CD4 is recommended for “test and treat” populations (e.g., pregnant and breastfeeding women, TB-infected patients, children <15 years).
- MOH plans to expand HVL testing capacity by adding more HVL testing facilities (either conventional or POC as technology evolves) in different parts of the Tanzania.
- The NACP at MOH will lead the HVL scale-up plan, and Regional Health Management Teams will manage the program in their respective regions.



# Laboratories Performing EID/HVL Tests

Tanzania





PEPFAR

## Viral Load Testing Volume

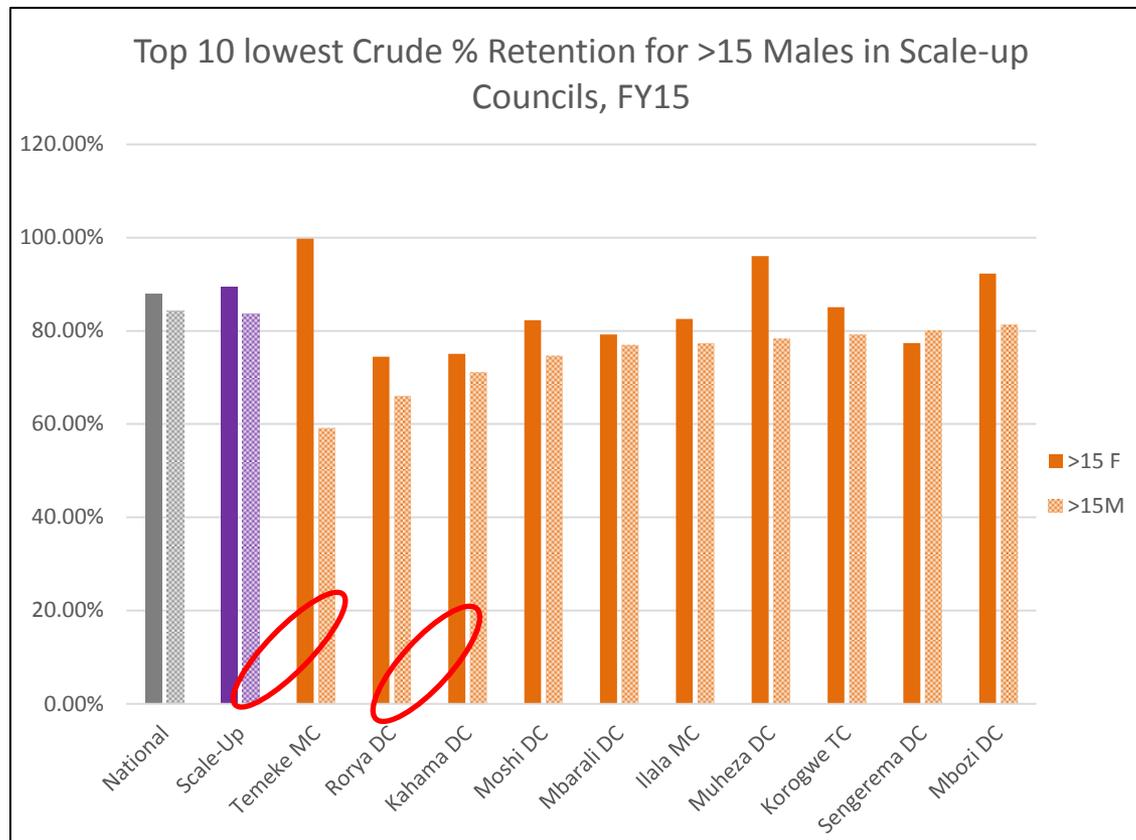
- Based on FY 15 program data, the estimated annual testing volume for HEID is 61,880 tests and HVL is 181,264 tests.
- The unused annual testing capacity is 202,696 for HEID and 243,056 for HVL as of February 2016.

	Testing Platform	FY 15 testing volume (A)	FY 15 testing capacity (B)	Unused testing capacity (B-A)
HEID	ROCHE (CAP/CTM)	61,880	264,576	202,696
HVL	ROCHE (CAP/CTM)	181,264	424,320	243,056



# Use council-level data to identify poor retention and most impacted sub-groups

*Retaining men in treatment is a challenge nationally. Using the gender analysis we can identify the 10 councils with the lowest retention rates and explore SNU-specific factors such as particular masculinity norms, mobility/employment or larger MSM communities which may contribute to even lower crude % rates [note DQA issues among females in Temeke to be explored]*

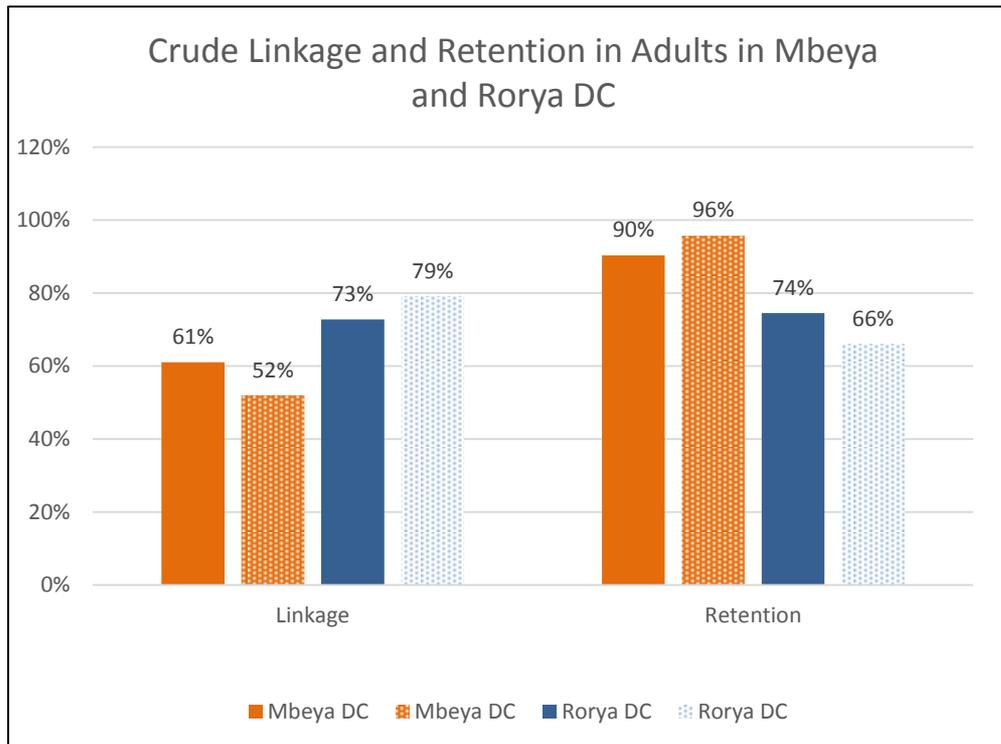


Test & Start and DREAMS



PEPFAR

# Using sex-disaggregated data to drive geographic-specific programmatic decisions



- In Mbeya DC (Mbeya) there are higher linkage rates for females than males but slightly lower retention rates for males than females
- In Rorya DC (Mara) there are slightly lower linkage rates for females than males but higher retention rates for females than males
- **Sex/age disaggregated data should drive programmatic decisions on how to focus linkage/retention efforts**



PEPFAR

## COP 16: Priority Strategies to Reach the 3rd 90

- Negotiated lease agreement for viral load machines (Cost per test: \$40 → \$14)
- Continue to support development of M & E tools and web-based dashboard
- Scale up Sample transportation & results return system
- Focus on retention and adherence using facility and community resources

*Impact of Unique Identifier on 3<sup>rd</sup> 90: Linkage and retention across the cascade; Linkage of VL results to patients*

# Web-Based Dashboard Example: EID and Viral Load

## GENERAL OVERALL STATISTICS - CUMULATIVE



Total Sample tested:  
104,006  
Total Sample  
collected: 106,430



Total Tested positive:  
7,091  
Total Sample tested:  
104,006



Total Reported sites:  
1,776  
Total EID site: 2,608



+ve Infants linked to  
CTC: 2



Total Kits in Stock:  
504  
Total Kits: 777



Median age of testing:  
7 week(s)



**PEPFAR**

**COP 2016 Plan for HIV Epidemic Control**

# **OTHER PROGRAM ELEMENTS**





# VMMC, DREAMS, GBV, OVC



PEPFAR

## VMMC age pivot

- **VMMC to focus on 10-29 year old males** for short and long-term impact
- **Specific plans to realize the 15-29 age pivot include:**
  - Targeted communication & demand creation
  - Improve service delivery to address client preference, convenience and seasonality
  - Outreach services – targeting workplaces and men in mobile occupations
  - Advocacy with GOT to prioritize 15-29

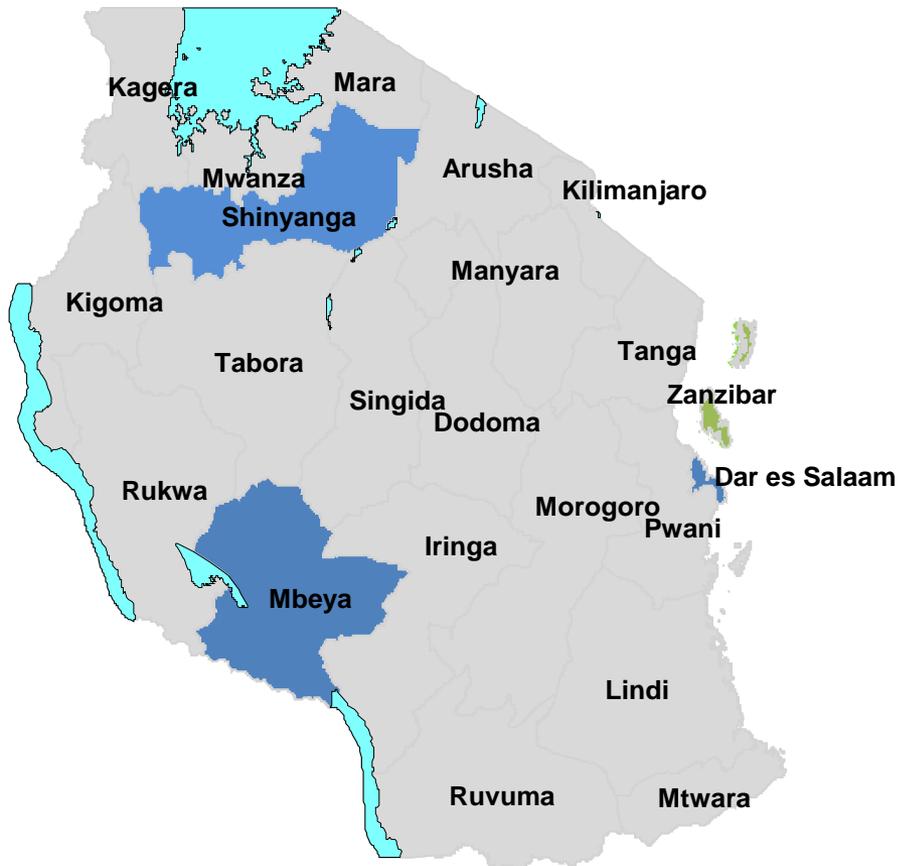


PEPFAR

# DREAMS – HIV Prevention for Girls and Young Women

## Progress to Date:

- DREAMS results reported quarterly
- Better identifying male partners
- Addressing negative gender norms
- Better Identification of girls and young women



## Implementation Challenges:

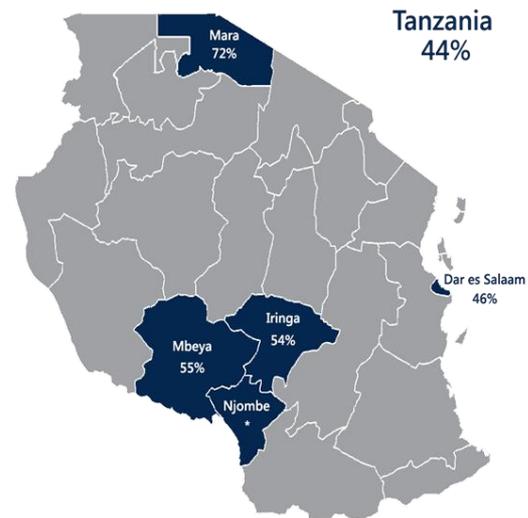
- HIV Testing Age of Consent
- Rolling out Test and Treat Guideline
- Sustainability of program and ensuring scale up



PEPFAR

# Care for Gender Based Violence (GBV)

	2014	% of total	2015	% of total
<15 Female	5028	7.6%	3467	7.2%
<15 Male	2322	3.5%	1923	4.0%
>15 Female	41135	62.4%	30820	63.8%
>15 Male	17402	26.4%	12074	25.0%



- Not enough males accessing post-GBV care
- Setting targets for post-GBV care is challenging
- Post-GBV Care rolling out to all priority councils
- In Mbeya, Post-GBV Care services being used more, with better training of clinicians, and greater community awareness



PEPFAR

## OVC Linkages

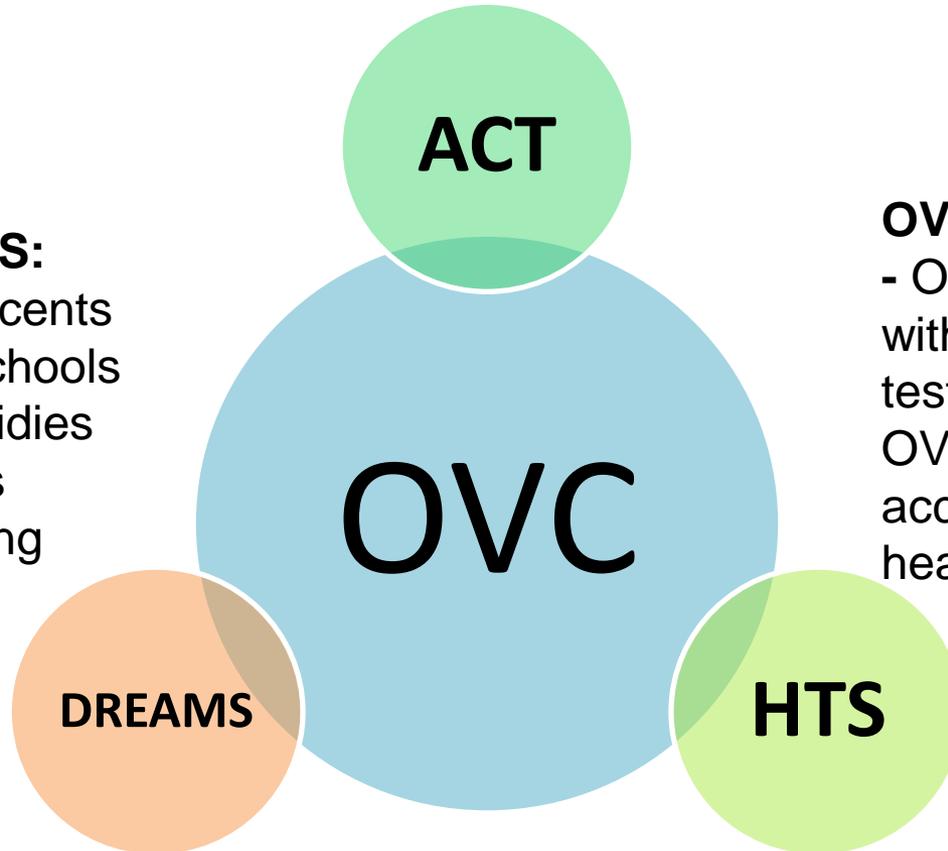
### OVC and ACT

Find more HIV exposed and HIV positive children

Oct-Dec 2015: 22-35% of new OVC were referred from facilities

### OVC and DREAMS:

- Keeping adolescents 10-14 safe in schools
- Education subsidies and implements positive parenting



### OVC and HTS

- OVC IPs will collaborate with HTS IPs to index testing for HIV exposed OVC who have never accessed HTS services at health facilities



**PEPFAR**

# **COP 2016 Plan for HIV Epidemic Control PROGRAM FINANCING**





PEPFAR

# Expenditure Analysis & COP 2016



# Expenditure Analysis (EA)

- PEPFAR collects expenditure data annually from all implementing partners, broken down by budget category
- EA data show how funds are divided by program area
- When combined with program targets, these data help to determine how much money is spent per beneficiary by each partner and in each locality
- EA data reflect programming from the previous year's COP



PEPFAR

# EA Categories

EA Category	Full Name
FBCTS	Facility Based Care and Treatment Services
CBCTS	Community Based Care and Treatment Services
PMTCT	Prevention of Mother to Child Transmission
VMMC	Voluntary Medical Male Circumcision
HTC	HIV Testing and Counselling
PEP	Post-Exposure Prophylaxis
BS	Blood Supply
IC	Infection Control
LAB	Laboratory
OVC	Orphans and Vulnerable Children
GP-PREV	General Population Prevention
KP-PWID	Key Population – People who Inject Drugs
KP-FSW	Key Population – Female Sex Worker
KP-MSMTG	Key Population – Men who have sex with men and trans-gendered people
PP-PREV	Priority Population Prevention
MAT	Medically Assisted Therapy (Methadone)
HSS TO SI	Health Systems Strengthening for Strategic Information
SURV	Surveillance
Cross-cutting PM to SI	Program Management under Strategic Information
Cross-cutting PM to HSS	Program Management under Health Systems Strengthening
Cross-cutting SI to HSS	Strategic Information under Health Systems Strengthening



# Distribution of EA FY15 Expenditure by Program Area

Table 3: Total PEPFAR Expenditures for Tanzania by Program Area and Fiscal Year

Program Area	2013		2014		2015	
	Spend (USD)	% of Spend	Spend (USD)	% of Spend	Spend (USD)	% of Spend
FBCTS	\$80,129,097	28 %	\$114,529,501	35 %	\$92,315,785	32 %
CBCTS	\$22,369,957	8 %	\$21,592,836	7 %	\$21,314,488	7 %
PMTCT	\$38,241,101	13 %	\$44,250,172	13 %	\$34,287,339	12 %
VMMC	\$16,911,731	6 %	\$24,547,531	7 %	\$30,980,993	11 %
HTC	\$22,334,425	8 %	\$21,186,124	6 %	\$19,304,325	7 %
PEP	\$956,327	0 %	\$1,889,875	1 %	\$1,121,369	0 %
BS	\$7,244,136	2 %	\$5,671,073	2 %	\$3,837,895	1 %
IC	\$4,828,516	2 %	\$6,921,186	2 %	\$3,291,534	1 %
LAB	\$23,021,821	8 %	\$24,460,221	7 %	\$22,451,355	8 %
OVC	\$24,160,135	8 %	\$22,153,801	7 %	\$20,135,106	7 %
GP-PREV	\$23,883,902	8 %	\$18,654,339	6 %	\$8,060,290	3 %
KP-PWID	\$4,521,346	2 %	\$2,215,101	1 %	\$2,121,360	1 %
KP-FSW	\$2,436,345	1 %	\$2,990,733	1 %	\$2,823,815	1 %
KP-MSMTG	\$912,676	0 %	\$1,221,865	0 %	\$1,190,321	0 %
PP-PREV	\$6,612,211	2 %	\$5,558,332	2 %	\$10,751,445	4 %
MAT	\$0	0 %	\$615,783	0 %	\$1,770,637	1 %
HSS TO SI	\$8,779,619	3 %	\$8,566,671	3 %	\$9,463,831	3 %
SURV	\$2,639,136	1 %	\$1,091,842	0 %	\$904,265	0 %
Cross-cutting PM to SI	\$0	0 %	\$385,457	0 %	\$564,969	0 %
Cross-cutting PM to HSS	\$894,540	0 %	\$1,850,615	1 %	\$1,759,498	1 %
Cross-cutting SI to HSS	\$76,475	0 %	\$860,160	0 %	\$1,932,484	1 %
<b>Totals</b>	<b>\$290,953,497</b>	<b>100 %</b>	<b>\$331,213,219</b>	<b>100 %</b>	<b>\$290,383,105</b>	<b>100 %</b>



PEPFAR

ASANTENI SANA!

